

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-002181

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED JAN 9 1962

1. PLACE OF DEATH

a. COUNTY

Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

Jackson

admission)

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN

Independence

Length of stay in lb

16 yrs.

c. CITY

OR TOWN

Independence

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

D.O.A. Indep. Hosp.

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

(If outside, give location)

1218 W. 35th Terr.

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

MR. KENNETH

Middle

ARTHUR

Last

MILLER

4. DATE OF DEATH

Month

January

Day

1, 1962

Year

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Sept. 17, 1910

51

9. AGE (last birthday)

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALES ENGINEER-Joslyn Mfg.-N.K.C., Mo.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Atherton, Mo.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Lee Miller

13b. MOTHER'S MAIDEN NAME

Ida Brown

14. NAME OF HUSBAND OR WIFE

Charline Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

Yes

(If yes, give year or dates of service)

W.W. II

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Charline Miller

Address

1218 W. 35th Terr., Indep., Mo.

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

30 min

DUE TO (b)

Coronary Artery Occlusion

30 min

DUE TO (c)

Atherosclerotic Heart Disease

5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

☐☐☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

July 1959

to Jan 1962

and last saw him alive on

Dec 8, 1961

Death occurred at approx. 6:40 P.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Robert S. Moxter MD

22b. ADDRESS

Independence, Mo

22c. DATE SIGNED

1-3-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

Jan. 4, 1962

23c. NAME OF CEMETERY OR CREMATORY

Floral Hills

23d. LOCATION (City, town, or county)

Raytown, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

OTT & MITCHELL, Indep., Mo.

25. DATE RECD. BY LOCAL REG.

1-4-62

26. REGISTRAR'S SIGNATURE

Alba T. Craig

(Licensed Embalmer's Statement on Reverse Side)

JAN 12 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3156

P. O. Address Dade Co, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.